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	495360	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WOODLANDS HEALTH AND REHAB CENTER	1000 FAIRVIEW HEIGHTS CLIFTON FORGE, VA 24422

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/20/2018 through 03/22/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 03/20/2018 through 03/22/2018. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 14 current Resident reviews and three (3) closed record reviews.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		5/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/04/2018

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F 657	Continued From page 1 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the CCP (Comprehensive Care Plan) for three of 17 residents was reviewed and revised in a timely manner. 1. The facility staff failed to review and revise the CCP regarding dementia interventions for Resident # 51. 2. The facility staff failed to review and revise the CCP regarding dialysis interventions for Resident # 2. 3. R 43's care plan was not revised to incorporate interventions for individual activities of interest. Findings include: 1. The facility staff failed to review and revise the CCP regarding dementia interventions for Resident # 51.	F 657	CORRECTIVE ACTION: The care plans for Residents #51 dementia interventions, #2 dialysis intervention, and #43 individual activities of interest were updated. IDENTIFYING OTHER RESIDENTS: Any resident has the potential for being affected by not having a current accurate care plan. A 100% audit of residents dementia interventions, dialysis interventions, and activities of interest was initiated on 03/26/18 by Nursing Administration, Nurse & RAI consultants, and designees. SYSTEMIC CHANGES: An inservice for the care plan team was initiated on 3/22/18 by RAI consultant on developing comprehensive accurate care plans, reviewing and revising care plans. MONITORING: 7 Care plans will be audited weekly by nursing administration, nurse consultants or designee x 8 weeks, then monthly x 2 months to ensure	

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Resident # 51 was admitted to the facility on 12/18/15 with the most recent readmission on 02/02/18. Diagnoses for Resident # 51 included, but were not limited to Alzheimer's dementia, dementia with behavioral disturbance, and chronic kidney disease.

The most recent MDS (minimum data set) was 30 day admission assessment dated 02/28/18. This MDS assessed the resident with a cognitive score of 2, indicating the resident was severely impaired in decision making skills.

On 03/20/18 at approximately 11:00 a.m., Resident # 51 was observed lying in his bed. The resident had colored construction paper cut out signs outside of his door. Two large signs with the resident's room number, with one also including the resident's last name and a third sign (cut out) of a large arrow pointing toward the nursing station.

An interview was attempted with the resident without success.

On 03/22/18 at 11:20 AM, Resident # 51's care plan was reviewed and documented that the resident had a 'communication deficit' related to dementia which impact decision making and requires direction from staff. The CCP interventions listed included the use of alternative communication tools as needed and listed signs specifically. Additional interventions were reviewed and documented, that the resident had a "sign/picture" with "Lexington Avenue" written on it the hung outside of resident's room for easier identification.

The resident and the resident's room was

accuracy. Findings of the audits will be reported to QAPI for further follow-up.

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observed multiple times throughout the survey process and there was no sign displayed as indication in the resident's CCP.

The interventions listed in the resident's CCP were implemented on 02/15/17. No revisions for this care plan intervention were found. No information was found to indicate that there was a change in signage for Resident # 51.

The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/22/18 at 4:30 p.m. The DON and administrator were asked why this CCP was not reviewed and revised to indicate the change in signage for the resident. The DON stated that different departments update the care plans and this one must have been missed.

2. The facility staff failed to review and revise the CCP regarding dialysis interventions for Resident # 2.

Resident # 2 was admitted to the facility on 06/20/16. Diagnoses for Resident # 2 included, but were not limited to: schizophrenia, end stage renal disease with hemodialysis on Monday, Wednesday, and Friday, COPD (chronic obstructive pulmonary disorder), anxiety, major depression, and anemia.

The most recent MDS (minimum data set) was quarterly assessment date 12/24/17. This MDS assessed the resident as having a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills.

On 03/20/18 at 3:03 PM, Resident # 2 was

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F 657	Continued From page 4	F 657		

interviewed and stated that she had dialysis on MWF (Mondays, Wednesdays and Fridays).

The resident's CCP (comprehensive care plan) was reviewed and documented that the resident was 'has nausea and vomiting' related to dialysis treatments and that the resident is to receive an antiemetic prior to dialysis treatments.

The resident's physician's orders were then reviewed and revealed that resident did not have an order for an antiemetic. The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed and did evidence that any antiemetic had been administered on dialysis days. The interventions were documented as being initiated on 12/12/16.

The above observations were discussed with the administrator and DON (director of nursing) in a meeting with the survey team on 03/22/18 at 4:30 p.m. The DON stated that she (DON) should have been the one to update this care plan, as she (DON) is often the one who review medication changes with the physician, but additionally stated that she (DON) did know how this change in information was missed and did not get updated on the CCP.

No further information was presented prior to the exit conference on 03/22/18 at 6:00 p.m.

3. R 43 care plan was not revised to incorporate interventions for individual activities of interest.

R 43 was admitted to the facility originally on

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F 657	Continued From page 5	F 657		

03/7/17 with a readmission on 1/4/18. Diagnoses for R 43 included, but were not limited to: DM (diabetes mellitus), major depression, paraplegia, end-stage renal disease receiving dialysis.

The most current MDS (minimum data set) was a quarterly assessment dated 02/27/18. R 43 was assessed with a cognitive score of 15, indicating cognitively intact.

On 3/20/18 at 1:45 p.m. an interview was conducted with R 43. During the interview R 43 verbalized that he spends most of the time in the dining room or in his bed. R 43 verbalized that the social activities was of no interest and did not participate in the activities mainly due to the age population of the facility (R 43 is younger that most of the other residents).

During the conversation R 43 expressed the want for independence and to be able to get out of the facility and go for a ride and do different things then just go from the bed to the dinning room. R 43 expressed depression, being bored and told this surveyor that the highlight of his week is when he goes out to dialysis.

Review of R 43's care plan for activities was reviewed. The care plan was initiated on 3/27/17 and had not been revised since initiated to include any new interventions. Interventions included: Ensure resident is aware of activities via calendar, provide transport to the activity center, and likes watching television shows.

On 03/22/18 02:09 PM the Activities Director (OS #1) was interviewed regarding activities for R 43. OS #1 verbalized R 43 has expressed to her that

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F 657	Continued From page 6 there is nothing in activities that interests him. When asked about if she (OS #1) has ever talked to R 43 in regards to what might interest R 43, OS #1 verbalized that given R 43's age he is not interested in what the population of the facility is doing and would probably benefit from computer activity and being able to go outside more often. When asked about R 43's activity care plan to include interventions that R 43 is interested in, OS #1 verbalized that she has had conversations with R 43 regarding activities, but has not revised the care plan to incorporate any new interventions. On 03/22/18 02:39 PM an interview with the nurse consultant (AS #4) was conducted regarding R 43's activity care plan. AS #4 reviewed R 43's care plan and agreed that the activity care plan should be revised to reflect R 43's interests and interventions to accommodate interests. 03/22/18 05:00 PM The above information was presented to the DON and administrator during an end of day meeting. No other information was presented prior to exit conference on 3/22/18	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679		5/1/18

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F 679	Continued From page 7 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure an ongoing program to support choice of activities for one of 17 residents, Resident #43 (R 43). R 43 did not have a activity program to individualize personal choice of activities. Findings include: R 43 was admitted to the facility originally on 03/7/17 with a readmission on 1/4/18. Diagnoses for R 43 included, but were not limited to: DM (diabetes mellitus), major depression, paraplegia, end-stage renal disease receiving dialysis. The most current MDS (minimum data set) was a quarterly assessment dated 02/27/18. R 43 was assessed with a cognitive score of 15, indicating cognitively intact. On 3/20/18 at 1:45 p.m. an interview was conducted with R 43. During the interview R 43 verbalized that he spends most of the time in the dining room or in his bed. R 43 verbalized that the social activities was of no interest and did not participate in the activities mainly due to the age population of the facility (R 43 is 57 younger that most of the residents). During the conversation R 43 expressed the want	F 679	CORRECTIVE ACTION: The Activity Director immediately interviewed Resident #43 and updated his plan of care to include his personal choice of activities. IDENTIFYING OTHER RESIDENTS: A resident council meeting was held on 04/02/18 to discuss activity preferences. Any resident has the potential to be affected if their individual activity preference are not identified. SYSTEMIC CHANGES: The Activity Director was inserviced by administrator on providing an ongoing program to support choice of activities on 03/26/18. MONITORING: Social Service Director or designee will interview 5 residents regarding personal choice of activities weekly for 4 weeks, then monthly for 2 months. 7 Care plans will be audited weekly by nursing administration, nurse consultants or designee x 8 weeks, then monthly x 2 months to ensure accuracy. Finding will be reported to QAPI for follow-up or recommendations.	

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F 679	Continued From page 8	F 679		

for independence and to be able to get out of the facility and go for a ride and do different things then just go from the bed to the dinning room. R 43 expressed depression, being bored and told this surveyor that the highlight of his week is when he goes out to dialysis.

Review of R 43's medical record conducted on 3/22/18, documented R 43 has been followed by psychology services and also evidenced that R 43 had major depression due to his condition and did not want to be at the facility to the point of suicidal thoughts (documentation indicated R 43 had been admitted to psych. services do to suicidal ideation).

Review of R 43's care plan for activities was reviewed. The care plan was initiated on 3/27/17 and had not been revised since initiated to include any new interventions. Interventions included: Ensure resident is aware of activities via calendar, provide transport to the activity center, and likes watching television shows.

On 03/22/18 02:09 PM the Activities Director (OS #1) was interviewed regarding activities for R 43. OS #1 verbalized R 43 has expressed to her that there is nothing in activities that interests him. When asked about if she (OS #1) has ever talked to R 43 in regards to what might interest R 43, OS #1 verbalized that given R 43's age he is not interested in what the population of the facility is doing and would probably benefit from computer activity and being able to go outside more often. When asked about R 43's activity care plan to include interventions that R 43 is interested in, OS #1 verbalized that she has had conversations with R 43 regarding activities, but has not revised the care plan to incorporate any new

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F 679	Continued From page 9 interventions. 03/22/18 05:00 PM The above information was presented to the DON and administrator during an end of day meeting. No other information was presented prior to exit conference on 3/22/18	F 679		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, facility staff failed to follow physician orders for fluid restrictions for one of 17 residents in the survey sample, Resident #28. Facility staff failed to accurately track and record 1000 cc (cubic centimeters) fluid restrictions for Resident #28 from March 9, 2018 through March 21, 2018. Findings included: Resident #28 was admitted to the facility on 02/14/18 and readmitted on 03/09/18 with diagnoses including, but not limited to: End	F 684	CORRECTIVE ACTION: CNA Staff were immediately educated by the Director of Nursing on 03/22/18 on the current fluid restriction order for resident #28. IDENTIFYING OTHER RESIDENTS: A 100% audit of fluid intake records for residents with fluid restriction was initiated on 03/26/18. SYSTEMIC CHANGES: An inservice was initiated on 04/05/18 for the certified nursing assistants by the dietician on accurately measuring and recording fluid intake.	5/1/18

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F 684	Continued From page 10 Stage Renal Disease requiring Hemodialysis, Congestive Heart Failure, Diabetes, and Depression. The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 02/27/18. Resident #28 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #28's clinical record was reviewed on 03/20/18 at approximately 2:00 p.m. During this review Resident #28's most recent POS (physician order sheet) dated 03/01/2018-03/31/2018 included the following entry, "...Renal diet Regular texture, Thin consistency, fluid restriction 1000ml/day [milliliters per day]..." Subsequent review of Resident #28's "Fluid Intake" sheet dated 3/9/2018 through 3/21/2018 included the following: 3/09/18 - 1200 cc 3/10/18 - 1440 cc 3/11/18 - 1900 cc 3/12/18 - 1380 cc 3/13/18 - 1500 cc 3/14/18 - 980 cc 3/15/18 - 1840 cc 3/16/18 - 1640 cc 3/17/18 - 1220 cc 3/18/18 - 1600 cc 3/19/18 - 1320 cc 3/20/18 - 1250 cc 3/21/18 - 1900 cc Resident #28 was over her daily fluid allowance everyday, except 3/14/18. The Dietary Manager (DM) was interviewed	F 684	MONITORING: Fluid intake records will be monitored for all residents with fluid restriction weekly x 4 weeks and then monthly x 2 months. Findings will be reported to QAPI for further recommendations and follow-up.	

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F 684	Continued From page 11 regarding Resident #28's diet and fluid order on 03/22/18 at 9:25 a.m. The DM stated, Resident #28 "is on a renal diet with 1000cc fluid restriction. I have a sheet that tells me how much fluid we can give her and how much nursing gives her. We give 240cc per tray." At approximately 9:45 a.m. the DM gave copies of the "Fluid Restriction Guidelines" sheet and Resident #28's "Dietary Slips" to this surveyor. Registered Nurse #1 (RN) was interviewed at approximately 1:10 p.m. regarding Resident #28's fluid restrictions. RN #1 stated, "Yes, she is on 1000cc/day. She gets fluid on her trays. She doesn't have a water pitcher at her bedside. She gets 90cc's of fluid with her meds [medications] and she gets meds three times a day. I do not record her intake. The aides record under tasks." At 1:20 p.m. Certified Nursing Assistant #1 (CNA) was interviewed regarding Resident #28's fluid restrictions. CNA #1 stated, "Yes, she is on 1500cc/day. We get the information from the nurse's mostly. We can look it up on their Kardex in the computer too." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 03/22/18 at approximately 4:30 p.m. No further information was received by the survey team prior to the exit conference at 6:15 p.m.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		5/1/18

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F 686	Continued From page 12 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, facility staff failed to follow physician orders for the use of heel protectors for one of 17 residents in the survey sample, Resident #46. Resident #46 was never observed with heel protectors in place during the survey conducted 03/20/18 and 03/22/18 as ordered by the physician. Findings included: Resident #46 was admitted to the facility on 02/16/18 with diagnoses including, but not limited to: Hemiplegia, Hemiparesis, Dysphagia and Depression. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 03/01/18. Resident #46 was assessed as cognitively intact with a total cognitive score of 12 out of 15. Resident #46's clinical record was reviewed on 03/20/18 at approximately 3:00 p.m. During this	F 686	CORRECTIVE ACTION: The heel protectors were immediately placed on Resident #46 on 03/22/18. Resident #46 will be reassessed to determine if the heel protectors are necessary to meet the residents individual needs. IDENTIFYING OTHER RESIDENTS: All residents with heel protector orders will be reviewed starting on 03/28/18 to determine compliance of use. Any resident who uses heel protectors has the potential to be affected if they are not placed per physicians order. SYSTEMIC CHANGES: The Director of Nursing initiated an inservice for Licensed nursing staff on 03-23-18 on applying adaptive equipment per physicians orders. MONITORING: Nursing Administration or designee will complete rounds on assistive devices 2x a week for 4 weeks and then monthly for 2 months to ensure devices are in place per physicians orders. Findings will be reported to QAPI	

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F 686	Continued From page 13 review Resident #46's current POS (physician order sheet) dated 03/01/18 - 03/31/18 included the following entry: "...Heel Protectors every shift for altered skin integrity..." Resident #48 was observed by this surveyor on 03/20/18 at 12:00 noon and again at 3:45 p.m. sitting in his w/c (wheelchair) without heel protectors in place. This resident was observed on 03/22/18 at 9:20 a.m., lying in bed without heel protectors in place. He was observed at 1:00 p.m., sitting up in his w/c without heel protectors in place. Registered Nurse #1 (RN) was interviewed on 03/22/18 at approximately 1:05 p.m. regarding Resident #46's use of heel protectors. RN #1 stated, "Yes, I believe he is supposed to have them on when in bed." RN #1 and this surveyor reviewed the physician orders for Resident #46. RN #1 stated, "Oh, he is supposed to have them on all the times. I will find some and have them put on him." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 03/22/18 at approximately 4:30 p.m. No further information was received by the survey team prior to the exit conference at 6:15 p.m.	F 686	Committee with any variances addressed.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		5/1/18

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F 883	Continued From page 14	F 883		

each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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F 883	Continued From page 15 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to implement the policy to ensure pneumococcal vaccine status was accurate upon admission to the facility. Four of five sampled resident records were incomplete for pneumococcal vaccine status. The fifth resident record documented refusal of the vaccine. Findings include: On 3/22/18 beginning at 11:00 a.m. the influenza and pneumococcal immunization status of five sampled residents was conducted. It was noted during the review four of the five sampled resident records the pneumonia vaccine was documented in the electronic medical record (eMAR) as "Pneumonia 1" and a date identified as "historical" indicating the vaccine was not received in the facility. One resident record indicated receipt of two pneumonia vaccines. Further review of the eMAR failed to reveal which pneumonia vaccine had been given to the resident, and if there was a plan to ensure resident's vaccine status would be brought up to date. On 3/22/18 at 1:30 p.m. the DON (director of	F 883	CORRECTIVE ACTION: The center Pneumococcal vaccine that was administered to all patients for the past two years was identified as Pneumococcal Polysaccharide Vaccine (PPVS23). The local health department was contacted to recommendations on vaccines that should be administered. IDENTIFYING OTHER RESIDENTS: A 100% audit of all current patients admission paperwork and immunization record was initiated on 03/23/18 to determine how many residents required further clarification on the type of vaccine that was administered. SYSTEMIC CHANGES: The Admission team was inserviced by the Director of Nursing on 3/22/18 on obtaining specific vaccine information during the admission process and documention on the admission packet. The Nurses were inserviced by the Director of Nursing on 03/22/18 regarding specific documentation requirements for historical pneumococcal vaccine and current vaccination procedures per CDC	

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F 883	Continued From page 16 nursing) was asked for clarification of the pneumonia vaccines as recorded in the eMAR. She was asked to identify which vaccine the resident had received, as well as what was in place to ensure completing the vaccine series. The DON confirmed to this surveyor the facility utilized the CDC (centers for disease control) guidelines for the administration of vaccines. A copy of the policy was provided to this surveyor. The policy "Pneumococcal Vaccination" was reviewed at that time to reveal "Policy: To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The attending physician will evaluate the resident/patient vaccination status on admission and will order the appropriate vaccine according to CDC guidelines." The policy further directed to refer to CDC attachments for the recommended vaccination schedule of the pneumococcal vaccine as there are two types of vaccine recommended based on age and vaccine history. The two types of vaccine are identified as "Pneumococcal Polysaccharide Vaccine (PPVS23)", and "Pneumococcal Conjugate Vaccine (PCV13)." The CDC reference also directed "Both PCV13 and PPVS23 should be administered routinely in series to all adults aged 65 years or older." On 3/22/18 at 1:45 p.m. the DON informed this surveyor "Well, I found out that we don't know which pneumococcal vaccine had been given to the residents. They [resident and/or family] are asked on admission if they have had the pneumonia vaccine, and if they are alert and	F 883	guidelines. MONITORING: Nursing Administration or designee will audit pneumococcal vaccine documentation for 5 patients weekly x 4 weeks and then monthly x 2 months. Findings will be reported to QAPI for recommendations and further follow-up.	

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F 883	Continued From page 17 oriented we just write down the date they give us. We don't get the physician's name or where they got the vaccine; I didn't realize the type of vaccine they got wasn't identified until today. We will make sure all new admissions are verified of which vaccine they got so we can then give the vaccine needed to complete the series." The DON further stated the resident with two pneumococcal vaccines had been admitted originally in 2016, and readmitted 11/2017, and both admissions stated he had the pneumococcal vaccine. The DON was asked if the resident had named the same vaccine twice, or had the facility verified the information to determine what the vaccination status actually was for the resident. The DON stated "That's a good point; I don't know if he actually had two vaccines, or he just gave a verbal 'yes' to the question on each admission if he had been given the pneumonia vaccine." On 3/22/18 during a meeting with facility staff beginning at 4:30 p.m. the administrator and corporate consultant staff were informed of the above findings. No further information was presented prior to the exit conference.	F 883		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, staff interview and facility document review, the facility staff failed to ensure an	F 925	CORRECTIVE ACTION: A work order was recorded for the gnats in the room for Resident #2. The Director of	5/1/18

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F 925	Continued From page 18 effective pest program. The facility staff failed to ensure the facility was free of 'gnats' and/or 'fruit flies. Findings include: On 03/20/18 at approximately 1:30 p.m., Resident # 2 was interviewed briefly in her room. The resident was lying in her bed, covered. The resident had a small can of soda sitting on the over bed table, in front of her. Multiple gnats/fruit flies were observed flying around the resident and the resident's drink/bed side table . The resident was asked about gnats/fruit flies flying around in the room. Resident # 2 stated that she was getting tired of them (gnats) and that a gnat had landed on her face and she did not appreciate it. An interview was attempted with Resident # 2's roommate, that resident was unable to provide information. On 03/22/18 at approximately 12:15 p.m., the resident was visited again. The gnats/fruits flies were still flying around in the resident's room. On 03/22/18 at approximately 1:55 PM, the ESM (Environmental Service Manager), was interviewed regarding any reports from staff and/or residents regarding gnats/fruit flies. The ESM stated that the reports are sporadic and have come from several different sources. The ESM stated that he may get reports from CNA's (certified nursing assistants) or residents. The ESM stated that their pest control company (Name of company) came on 03/07/18 and documented for the treatment of 'spiders'. The ESM stated that he doesn't document what he	F 925	Maintenance completed a treatment for the gnats in the residents room on 3/22/18. IDENTIFYING OTHER RESIDENTS: Environmental rounds of the facility were completed on 03/22/18 to determine if any other pest were identified. The Pest Control Provider was contacted and scheduled to treat specifically for gnats/fruit flies on 4/06/18. All residents had the potential to be affected by not maintaining an effective pest control program. SYSTEMIC CHANGES: The Pest Control provider was educated by the Maintenance Director and Administrator on appropriate and accurate documentation for services provided on a monthly and as need basis. An inservice for facility staff by Maintenance Director and Administrator was initiated on 03/26/18 on documenting work orders in the Maintenance TELS system so that there is adequate documentation of completed work. MONITORING: Environmental rounds for pests will be completed by Maintenance Director or designee 5x per week x 4 weeks, then weekly x 4 weeks, then monthly for 2 months. Findings will be reported to QAPI for recommendations and follow-up.	

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F 925	Continued From page 19	F 925		

does for treatment and pest control company normally doesn't either. The pest control company usually write on the invoice what chemical they use. The ESM stated that it is usually the same rooms that have issues with the gnats. The ESM stated that they (pest control) come each month.

The invoices for pest control for January, February, and March all documented that the facility was treated for spiders, there were no specific areas documented for treatment (i.e. room numbers, kitchen, common areas, etc). The ESM stated that the last report he got on gnats was in January, but did not state where that report came from and there was no documentation of that report. The ESM also stated that he had treated for them, but could not provide documentation of what was treated, what type of treatment, or what areas were treated. The ESM stated that the gnats/fruit flies 'usually has something to do with residents dumping food and/or drink down the drains in the rooms'.

The ESM stated, "I haven't put in a work order for that [gnats/fruit flies], I usually just wait on him (pest control)." The ESM looked into the computer system for work orders/concerns and stated that there has not been any work orders since back in August. The ESM that the staff can go into the computer system and document a work order to come to me for specific issues.

The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 03/22/18 at approximately 4:30 p.m.

No further information and/or documentation was provided prior to the exit conference on 03/22/18

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F 925	Continued From page 20 at 6:15 p.m.	F 925		